



Department of Medical Assistance Services
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Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Psychiatric Residential Treatment Providers, and
Managed Care Organizations Participating in the
Virginia Medical Assistance Programs, and all CPMT
Chairpersons

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 5/30/2008

SUBJECT: New Prior Authorization Process for Level A (Children's Group Home) and Level
B (Therapeutic Group Home) Psychiatric Residential Treatment Facility Providers
– Effective July 1, 2008

The purpose of this memorandum is to provide information regarding changes in criteria for Level A Children's Group Home and Level B Therapeutic Group Home Psychiatric Residential Treatment Facility (PRTF) services and notification of the new prior authorization (PA) requirements with Virginia Medicaid's PA contractor, Keystone Peer Review Organization (KePRO).

Level A and B PRTF's offer community-based residential services for children and adolescents under 21 and are a combination of therapeutic services rendered in the residential setting. Services will provide structure for daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals. Only facilities with 16 or fewer beds are eligible to provide these services. For Level B PRTF's, the child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Authorization is required for Medicaid reimbursement.

Level C PRTF's provide residential inpatient care and is a 24-hour-per-day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders. All services must be provided at the facility as part of the therapeutic milieu.

This memo addresses prior authorization requirements for Level A and B PRTF services. Level C services currently require PA through KePRO. Effective July 1, 2008, all Level A and Level B

PRTF's will require prior authorization for the initial admission, as well as continued stay. Requests for prior authorization for dates of service on or after July 1, 2008 must be submitted to KePRO.

WebEx (web-cast training) will take place May 15, 2008 from 3p.m. to 4p.m. to provide instructions on how to submit requests for services through KePRO. To log on to the WebEx, go to www.genesys.com and click on "join a meeting as a participant". Enter the meeting number: *9240330*, then choose "*How to submit a successful PA for Level A and Level B*". The audio call-in number is 1-866-462-0164. This WebEx will be recorded and available on the KePRO website after May 15, 2008 to view at your convenience.

Criteria

For dates of service on or after July 1, 2008 KePRO will use *McKesson InterQual® Level of Care, Behavioral Health Criteria, Residential & Community Based Treatment, 2008* and DMAS criteria to determine initial admission and continued stay requests.

Clinical information needed from provider for authorization

Initial Review – documentation must be submitted to KePRO within three business days of admission unless the service is for a patient who is determined to be retroactively eligible for Medicaid benefits.

- For Level A & B services, individuals must have a primary diagnosis of mental illness that meets the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I disorder.
All 5 axes are required to be documented in the medical record.
- If this is a dual diagnosis of Mental Health (MH) and Substance Abuse Services (SAS), the focus of treatment must be the MH problem. Medicaid does not cover inpatient or residential treatment of substance abuse disorders.
- Description of symptoms and behaviors within the last week.
 - The symptoms and behaviors should reflect impairments that are significant enough to support the need for out-of-home placement and are anticipated to be chronic in nature, and endangering of self or others. Descriptions should be child-specific.
- Description of social risk within the last month.
 - Failed treatments
 - Specifically, what service(s) had been attempted and the reason they failed.
 - Support system
 - Brief description of deficits that support the need for a residential placement.
- Description of current level of functioning.
 - Ability to follow directions
 - Ability to interact appropriately with others
 - Ability to maintain age-appropriate behavior
- Provide date of Certification of Need (CON)/Independent Team Certification, and confirmation that all required information and appropriate dated signatures are in the medical record. The CON must be completed prior to admission.
- Provide the date of the Initial Plan of Care (IPC), and confirmation that all required information and appropriate dated signatures are in the medical record. The IPC must be completed within three days of admission.

- Provide the date of the Universal Assessment Instrument (Comprehensive Services Act - CAFAS or PECFAS) or assessment (non-CSA) for supporting placement at this level of care. This must be completed prior to the admission.

If all criteria are met, KePRO will approve for up to 6 months.

Concurrent Review (same provider) documentation must be submitted to KePRO no earlier than 30 days prior to end of current authorization

- For Level A & B services, individuals must have a primary diagnosis of mental illness that meets the DSM-IV-TR diagnostic criteria for an Axis I disorder.
All 5 axes are required to be documented in the medical record.
- If this is a dual diagnosis of MH and SAS, the focus of treatment must be the MH problem. Medicaid does not cover inpatient or residential treatment of substance abuse disorders.
- Describe continuing or new symptoms and behaviors within the last month that support the need for residential care and that reflect the DSM-IV diagnosis.
- Describe social and behavioral functioning within the last month.
- Provide the date of the Comprehensive Individual Plan of Care (CIPOC) and confirmation that all required information and appropriate dated signatures are available in the medical record. The CIPOC must be completed within 30 days of admission.
- Provide the date of the most recent CIPOC update (current to within past 30 days), and confirmation that all required information and appropriate dated signatures are available in the medical record.
- Confirm all required therapeutic services are provided as the level of care requires.
- Provide anticipated discharge plan and date. If this has changed, explain why.

If all criteria are met, KePRO will approve for up to 6 months.

Additional information regarding Level A and B Psychiatric Residential Treatment Facility requirements, as well as billing instructions, are located in the *Community Mental Health Rehabilitative Services Manual* located on DMAS' website.

When to Submit Requests to KePRO

Currently, providers are performing a 'self PA process' which takes place with the initial admission, then every six months if there is a need for continued stay. Effective July 1, 2008, for newly admitted individuals with an admission date on or after July 1, 2008 the provider must submit requests to KePRO within three business days of admission. For individuals that require continued stay, prior to the next self PA expiration date, instead of the provider performing the self PA, providers are required to submit the continued stay request to KePRO. PA requests must be submitted no earlier than 30 days prior to the end of the current PA, and no later than the last day of the current PA. Initial admission requests will be approved for up to six months; continued stay reviews will be approved for up to six month increments. Providers will begin receiving their official authorization determinations (denials or approvals) via the First Health automated letter generation process. The letter generated from First Health will include a PA number. This number must be used when submitting claims. Claims submitted for services that exceed the units authorized will be denied.

Submission Methods

KePRO will accept requests for PA via iEXCHANGE (direct data entry through the web), fax, mail, or phone. The preferred method of submission for requesting PA is through iEXCHANGE.

You must have a provider web account before submitting information through iEXCHANGE. To register for a web account, you must know your National Provider Identification (NPI) and tax identification number. You will receive a log on pass code within 10 days of registration. To submit requests via iEXCHANGE, log on to DMAS.KePRO.org and register for a provider web account. Submit requests for dates of service on and after July 1, 2008 via phone, fax, or mail to:

KePRO

Toll Free Phone: 1-888-VAPAUTH (1-888-827-2884)

Local Phone: (804) 622-8900

Fax: 1-877-OKBYFAX (1-877-652-9329)

2810 N. Parham Road, Suite 305

Richmond, VA 23294

To submit requests by fax, or mail you must complete the request on the DMAS 365-A/B (Level A and B - PRTF Preauthorization Request Form and instructions), which is attached to this memo. This form and its instructions identify critical information to process Level A and Level B RTF PA requests (i.e., whether received by web, fax, phone, or paper). Complete all boxes on the fax form to insure a quick response to your request.

What to Submit to KePRO

For CSA requests only, the 3-digit locality code is required. The locality code will reflect the locality that has fiscal responsibility for the Medicaid recipient and must be submitted to the provider by the referral source. The locality codes are in the *Community Mental Health Rehabilitative Services* manual, Chapter I, Exhibits. These locality codes are also in the KePRO fax form instructions.

The following procedure codes must be used with the associated modifiers when submitting requests to KePRO on the DMAS 365A/B:

Procedure Code and Associated Modifier	Service Description
H2022, HW	Level A (CSA)
H2022, HK	Level A (Non-CSA)
H2020, HW	Level B (CSA)
H2020, HK	Level B (Non-CSA)

Alternate Methods to Obtain PA, Eligibility and Claims Status Information

DMAS offers an enhanced web-based Internet option Automated Response System (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same

information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access prior authorization information including status via iEXCHANGE at <http://dmas.kepro.org/>.

Copies of Manuals

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the “DMAS Content Menu” column on the left-hand side of the DMAS web page for the “Provider Services” link, which takes you to the “Manuals, Memos and Communications” link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

Provider E-Newsletter Sign-Up

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at: www.dmas.virginia.gov/pr-enewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

Attachments: (5 pages)



Community Based Residential Services for Children & Adolescents Level A&B Prior Authorization Request Form

KePRO & DMAS now require that any Medicaid Provider submitting Prior Authorization Requests using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide a 9 digit Zip code. If you do not know your 9 digit Zip code, please visit: <http://zip4.usps.com/zip4/welcome.jsp>

Fax: 1-877-OKBYFAX (877-652-9329) Phone: 1-888-827-2884

☐ Initial Review ☐ Continued Stay Review ☐ Retro Authorization ☐ Transfer

1) <input type="checkbox"/> CSA Modifier HW Locality Code: <input type="checkbox"/> Non-CSA Modifier HK		2) Service Type: <input type="checkbox"/> Level A (0752) <input type="checkbox"/> Level B (0753)		3) Requested Start Date: / / Admission Date: / /		4) Expected Discharge Date: / /	
5) Enrollee Last Name:		6) Enrollee First Name:			7) Enrollee Medicaid ID #:		
8) Date of Birth(mm/dd/yyyy): / /		9) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		10) Provider Name:		12) Provider Address (including required 9-digit Zip Code):	
		11) Provider NPI/API Number:					
13) Contact Person:		14) Provider Phone Number:			15) Provider Fax Number:		
16) DSM IV Diagnostic Codes: Axis I _____ Axis II _____ Axis III _____					Axis IV _____ Axis V (GAF): Current: Highest level in past 6 months:		

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Community Based Residential Services for Children & Adolescents Level A&B Prior Authorization Request Form

17) Enrollee Last Name:	18) Enrollee First Name:	19) Enrollee Medicaid ID Number:
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20) INITIAL REVIEW

Initial Plan of Care (IPC) with all the required elements completed, signed, and dated within 3 days of admission (*signed by QMHP for Level A; LMHP for Level B*)? ☐ Yes ☐ No Date of IPC:

For CSA:

a. CON signed and dated by the physician and 3 members of the team? ☐ Yes ☐ No Date of CON:

b. CAFAS documenting at least 2 moderate impairments and current within 30 days of admission? ☐ Yes ☐ No Date of CAFAS:

For Non-CSA:

a. Certification of services completed, signed and dated by physician and LMHP? ☐ Yes ☐ No Date of Certification:

b. Assessment documenting 2 moderate impairments completed by PCP or EPSDT physician and LMHP? ☐ Yes ☐ No
Date of Assessment:

If NO to any of the above, please explain:

21) CONCURRENT REVIEW

a. Comprehensive Individual Plan of Care (CIPOC) completed within 30 days of admission with dated signature (*signed by QMHP and Program Director for Level A; LMHP for Level B*)? ☐ Yes ☐ No Date of CIPOC:

b. CIPOC updated every 30 days with dated signature (*signed by QMHP for Level A; LMHP for Level B*)? ☐ Yes ☐ No
Date of CIPOC update:

c. Weekly individual psychotherapy provided by LMHP? ☐ Yes ☐ No

d. Seven (7) psycho educational activities provided each week? ☐ Yes ☐ No

e. Group psychotherapy provided by LMHP (*Level B only*)? ☐ Yes ☐ No

If NO to any of the above, please explain:

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**Community Based Residential Services for Children & Adolescents Level A&B
Prior Authorization Request Form**

CONFIDENTIAL

Enrollee Last Name:	Enrollee First Name:	Enrollee Medicaid ID Number:
<p>22. Severity of Illness / Current Behaviors: For the Initial Review, provide a narrative of the behaviors exhibited by the client within the last week that warrant the requested level of care (please identify frequency, intensity, and duration of behavior). Describe failed treatments within the past month. Describe support system. For continued stay, this information should come from the most current 30 day progress report. Describe functioning (peer relations, school behaviors, self-care) in past month.</p>		

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DMAS 365 Level A & Level B RESIDENTIAL TREATMENT CARE ELECTRONIC FAX FORM INSTRUCTIONS

Web Resources: www.dmas.kepro.org
www.dmas.virginia.gov

This FAX submission form is required for Level A & Level B Residential Treatment Care (RTC) prior authorization review.

Please ensure that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via fax for additional information.

If KePRO determines that your request meets appropriate review guidelines, the request will be “tentatively approved” and transmitted to First Health Services (FHS) for final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to you via the web-based program iEXCHANGE (<http://dmas.kepro.org>) within 24 hours of the decision.

- **Please check the appropriate type of review (INITIAL, if this is a first time request; CONTINUED STAY, if services are continuing; RETRO, if Medicaid eligible after services begun, or TRANSFER, if services were transferred from another provider)**
 1. **Please place an X on either CSA Modifier or Non-CSA Modifier and enter the 3-digit Locality Code**
 - **Enter the 3-digit Locality Code for CSA request only**
 - The **Locality Code** reflects the locality that has fiscal responsibility for the Medicaid recipient
 2. **Please mark with an X the appropriate type of service (Level A or Level B)**
 3. **Requested Start Date/Admission Date**
 - Please enter the appropriate dates
 4. **Expected Discharge Date**
 - Please enter the expected discharge date
 5. **Enrollee Last Name**
 - Enter the enrollee's last name exactly as it appears on the Medicaid card
 6. **Enrollee First Name**
 - Enter the enrollee's first name exactly as it appears on the Medicaid card
 7. **Enrollee Medicaid ID Number**
 - Please ensure that the enrollee's Medicaid number is valid and contains 12 digits (*this is the Provider's responsibility*)
 8. **Date of Birth**
 - Enter the enrollee's date of birth in the MM / DD / YYYY format (for example, 02/25/2008)
 9. **Gender**
 - Please mark the appropriate gender of the recipient
 10. **Provider Name**
 - Enter the requesting provider's name

11. Provider NPI/API Number

- Enter the Provider NPI/API number. A 10 digit number is used for the National Provider Identifier or Atypical Provider Identifier

12. Provider Address (including required 9-digit Zip Code)

- Enter the provider's service address
- **9 Digit Zip Code (Required):** Providers must enter their 9 digit Zip code to ensure that their correct location is identified for the National Provider Identifier (NPI) number

13. Contact Person

- Enter the primary contact for the requesting provider

14. Provider Phone Number

- Enter the phone number of the requesting provider

15. Provider Fax Number

- Enter the fax number of the requesting provider

16. DSM-IV Diagnostic Codes

- Enter the appropriate DSM-IV diagnosis on all 5 Axes

17. Enrollee Last Name

- Please re-enter the enrollee's last name on each page of your submission

18. Enrollee First Name

- Please re-enter the enrollee's first name on each page of your submission

19. Enrollee Medicaid ID Number

- Please re-enter the enrollee's valid 12 digit Medicaid number on each page of your submission

20. Initial Review

- Please answer the questions and explain any "NO" answers at the bottom of the section

21. Concurrent Review

- Please answer the questions and explain any "NO" answers at the bottom of the section

22. Additional Information

- Enter Severity of Illness and Intensity of Services from McKesson InterQual ® Level of Care, Behavioral Health Criteria, Residential & Community Based Treatment 2008 and the Community Mental Health Rehabilitative Services Manual. Include any additional comments in the spaces provided